CAREGIVER HEALTH EVALUATION

Name: _____ Social Security Number: _____

Address:

_____

Phone Number: _____Job Title: _____

Family Physician: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

Do you have any allergies to (*circle all that apply*):

A. Latex or vinyl B. Chemicals/household products C. Soaps or personal care products

D. Foods E. Pollens/dusts F. Certain types of clothing/gloves

Check the box that describes the communicable diseases, vaccinations, or antibody titers you have had. Please include the date(s) of illness, vaccinations or titer completion.

Disease yes/no	Vaccine yes/no	Date	
☐ ☐	☐ ☐	_____	Rubeola (red measles - 7 day)
☐ ☐	☐ ☐	_____	Rubella (German measles - 3 day)
☐ ☐	☐ ☐	_____	Mumps
☐ ☐	☐ ☐	_____	Hepatitis B
☐ ☐	☐ ☐	_____	Chicken Pox
☐ ☐	☐ ☐	_____	Tetanus/Diphtheria
☐ ☐	☐ ☐	_____	Polio
☐ ☐	☐ ☐	_____	Pneumococcal
☐ ☐	☐ ☐	_____	Tuberculosis

If you have had a positive TB skin test, date of skin test conversion: _____
Last chest X-ray date: _____ Result: _____

Please note: if you are pregnant or planning pregnancy, please discuss the occupational risks peculiar to your position (such as exposure to communicable diseases, exposure to cleaner/ disinfectant fumes, lifting, etc.) with your physician.

I have discussed with the licensee any condition which may prevent me from performing assigned duties satisfactorily. I understand that all information will be kept confidential.

The information on this health evaluation is complete and accurate to the best of my knowledge. I hereby certify that I am free of any physical, mental, or emotional conditions which would be detrimental to the well-being of the children in my care.

_____ _____

(Signature) (Date)